Hello and welcome to this podcast from NICE on the melanoma guideline. In this podcast we will be discussing the evidence behind recommendations on sentinel lymph node biopsy, and how these recommendations can be implemented. With me is Barry Powell, Consultant Plastic Surgeon at St George’s Hospital, London. Barry was a member of the group that helped develop the guidelines for NICE.

Q1: “So what is sentinel lymph node biopsy and why is it healthcare professionals currently use it for patients with melanoma?”

“So, a sentinel lymph node biopsy is a test, and one has to stress it’s a test, to see if melanoma has spread.

“When a skin cancer like melanoma spreads it likes to spread through what we call the lymphatic system and that means the melanoma will travel in the lymphatics until it reaches the glands or the lymph nodes. And the sentinel node is defined as the very first lymph node that a melanoma cell would arrive at if it was to spread.

“So it’s important to stress though it’s an investigation which lets us as healthcare professionals know, has your melanoma spread. It does not offer you any form of increased survival benefit but lets you know where you are in your disease progress.”

Q2: “And what does the current evidence say on the efficacy of a sentinel lymph node biopsy?”

“So that’s a good question. People who undertake sentinel lymph biopsy, these are surgeons who undertake it, are extremely experienced at doing it. And we work on the principle that we would identify the sentinel node in over 98 per cent of patients who have the procedure.

“The question about the efficacy is purely based on, I think, the reliability. And we know that removing the sentinel node and having it analysed by the pathologist is an extremely reliable way of identifying if your melanoma has got to the lymph glands.”

Q3: “So what does NICE recommend in the new guidance on the use of sentinel lymph node biopsy?”

“So I think it’s important to say that NICE has moved quite a distance in the recommendations it made in 2006. In 2006, NICE recommended that
sentinel node biopsy was only undertaken as part of a clinical trial. But we are now just under 10 years later and we have understood the real role that sentinel node has in the management of patients with melanoma.

“So NICE says that the sentinel node biopsy should be considered in patients. Now, the term ‘considered’ is extremely important. What it says is that it gives healthcare professionals information but the evidence isn’t completely conclusive that it is correct but it is felt that more times than often it is done in the patient’s best interests. And on the basis of that NICE says to consider sentinel lymph node biopsy.”

Q4: “So what does this mean for healthcare professionals and how might they put these recommendations into practice?”

“So the first thing is that any healthcare professional who is involved in looking after patients with melanoma should always offer those patients the opportunity to have a sentinel node. If they work in an environment where they are unable to offer that technique themselves then they should be encouraged to refer them to a centre where it is offered.

“In order to help this decision making process, and it is a difficult one, NICE has established an option grid, which is a system whereby the doctor talking to the patient can tell the patient the advantages and the disadvantages of having a sentinel node biopsy, and to help the patient come to a decision on which they felt would be in their best interest.”

Q5: “What happens when the biopsy test comes back with a positive result?”

“So first of all it’s definitely not a doom and gloom situation if a patient has what we call a positive sentinel node biopsy. Because we know from the data that there are still a large number of patients who will be alive and well despite having a positive test.

“NICE looked very carefully at what the recommendations should be and at the present time, once again, we have stressed that a patient should consider going on to having a further operation in which all the remaining lymph nodes are removed. We call it a completion lymph node dissection. It is essentially going back to the same area where the sentinel node was identified and removing the rest of the lymph glands.”
Q6: “Could you expand on why NICE has used the term ‘considered’ for this particular explanation?”

“So the reason NICE has said to consider is the first thing we have to say again, is that the data shows that there is no additional survival benefit. So that means if a patient has this additional operation we cannot say to them that they will have a better survival than if they didn’t. The reasons why we would suggest the ‘consider’ is that it reduces the risk of patients having disease re-growing in that lymph node basin, which is something that patients don’t want to do. It allows patients to be selected for some of the new advanced trials that are available. And it is important because many of the new trials will only select patients who have had a sentinel node as part of a staging procedure. So that is why NICE has said that we would consider it.

“One of the things with sentinel node biopsy is it provides the best information about whether melanoma has spread. And clinicians call this staging. This is a term that’s used to indicate whether the patient has disease that is local or has spread distantly. So, for example, with melanoma of 10 people who have had a negative sentinel node biopsy we can say that 9 of those people will still be alive and well 5 years later. If the sentinel node is positive, that means to say they have the disease, then 7 patients will be alive and well 5 years later. And that’s where the role of sentinel node comes in is identifying those risks.”

Dr Powel, thank you very much.

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